Varicella Zoster IgG RELEASE FORM

COMPLETE ALL PAGES AND FAX TO: FFF ENTERPRISES AT 1-800-418-4333

SUBJECT INFORMATION:

SUBJECT INITIALS	First Middle Last
DATE OF BIRTH	(MMM) • (DD) • (YYYY)
GENDER	MALE FEMALE
SUBJECT WEIGHT	**KG** (REQUIRED TO CALCULATE # OF VARIZIG™ VIALS)

SUBJECT EXPOSURE TO VARICELLA ZOSTER VIRUS (VZV):

Type of Exposure	
Duration of Exposure	Days Hours Min
Time since Exposure	Days Hours Min

IS THE SUBJECT ANY OF THE FOLLOWING "AT RISK" GROUPS WHO HAS BEEN EXPOSED TO VARICELLA ZOSTER VIRUS? (CHECK ALL THAT APPLY):

Yes No

- Child with cellular immunodeficiency or neoplastic diseases, or child receiving immunosuppressive therapies
- Newborn of mother with VZV < 5 days before or < 2 days after delivery.
- Premature infants
- Full term infant < 1 year of age
- Immunocompromised adult with no history or evidence of prior infection
- Healthy adult with no history or evidence of prior VZV infection
- Pregnant woman with no history or evidence of prior VZV infection

IF THE SUBJECT DOES NOT BELONG TO AN "AT-RISK GROUP", THEY ARE NOT ELIGIBLE TO PARTICIPATE IN THIS TRIAL

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SUBJECT EXCLUSION CRITERIA

IF THE ANSWER TO QUESTIONS 1, 2 OR 3 IS **"YES"**, THE SUBJECT IS **NOT ELIGIBLE** TO PARTICIPATE IN THIS TRIAL

		Yes	No
1.	Does subject have a known immunity to VZV, i.e. previous infection or vaccination?		
2.	Does subject have medical history of IgA deficiency?		
3.	Does subject have a history of hypersensitivity to immune globulins?		
4.	Does the subject have evidence of varicella or zoster lesions prior to dosing?		
5.	If potential subject is premature infant that is 28 weeks or more gestational age, has the patient's mother ever had varicella?		

PHYSICIAN'S ELIGIBILITY FOR CLINICAL TRIALS

IF THE ANSWER TO QUESTIONS 1OR 2 IS **"YES"**, THE PHYSICIAN IS **NOT ELIGIBLE** TO PARTICIPATE IN THIS TRIAL.

		Yes	No
1.	Have you ever been disbarred from performing a clinical trial?		
2.	Are you an employee of Cangene Corporation, or have you or your Institution received a significant benefit (such as payment, proprietary interest or equity) from Cangene Corporation?		

IF THE ANSWER TO QUESTIONS 3, 4 OR 5 IS **"NO"**, THE PHYSICIAN IS **NOT ELIGIBLE** TO PARTICIPATE IN THIS TRIAL.

		Yes	No
3.	Do you agree to sign and follow the protocol that will be sent with the varicella zoster immune globulin shipment?		
4.	Do you agree to administer the informed consent form (sent with the varicella zoster immune globulin shipment) to the patient?		
5.	Do you agree to complete and provide Cangene Corporation (or designate) with the required documentation for this trial (Hematology, Serum Chemistry, Measures of Varicella Infection)?		

I CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ Date: • •

Physician's Signature (MMM) (DD) (YYYY)

_____

Print Name of Physician

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First Middle Last

PHYSICIAN'S CONTACT INFORMATION:

NAME OF HOSPITAL OR MEDICAL FACILITY: _____ _____	**STREET ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____
PHONE NUMBER: (INCLUDE AREA CODE)	_____/_____/_____
FAX NUMBER (INCLUDE AREA CODE)	_____/_____/_____
E-MAIL ADDRESS:	

SHIPPING ADDRESS (IF DIFFERENT FROM ABOVE)

NAME OF HOSPITAL OR MEDICAL FACILITY: _____ _____	**STREET ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

TO BE COMPLETED BY FFF ENTERPRISES ONLY:

RELEASE AUTHORIZATION:

Is subject Eligible for the study **Yes** **No** **Total number of vials**: _____

_____ Date: • •

Signature (MMM) (DD) (YYYY)

_____

Print Name